Medicare Supplement Insurance Is Standardized

Congress passed legislation creating federal standards for Medicare Supplement insurance policies that the states are required to adopt, with the exception of Massachusetts, Minnesota, and Wisconsin.

Federally mandated standardization means that all Medicare Supplement insurance policies sold must contain a package of benefits conforming to one of the twelve standard plans that are designated as Plan A through Plan L. An outline of the benefits in each of the twelve standard plans is located on the last page of this handout.

As a result of standardization, comparison-shopping among different insurance carriers for Medicare Supplement insurance is relatively simple. For example, Plan C will contain the same benefits no matter which insurer sells it. Consumers can select policies based on premium cost and the special features or services offered by the Medicare supplement insurance company.

Standard Medicare Supplement Benefits

The basic benefits (also known as the "core benefits" or Plan A) are the minimum coverage you may buy. Plan A contains only the 3 core benefits listed below. Every other plan contains these three benefits as the "core" and then adds one or more additional benefits. Although Plan A is one of the least expensive policies, it may not be a good choice for low-income individuals who may not be able to afford the Medicare Part A hospital deductible when they are hospitalized.

(1) **Hospitalization**: Medicare Part A pays only a portion of the daily costs for hospitalizations. You must pay the coinsurance amounts for those days. This Medicare Supplement benefit pays the Part A coinsurance amount after the 60th day and an additional cost of 365 lifetime days.

(2) **Blood**: Medicare pays for all blood that is medically necessary except for the first three pints in each calendar year.

This Medicare Supplement benefit pays for the first three pints of blood not paid for by Medicare, or equivalent quantities of packed red blood cells, as defined under federal regulations.

(3) **Medical Expenses**: Generally Medicare Part B pays for 80% of a predetermined amount (called the "Medicare approved" amount) for each procedure, supply, or service billed by your doctor or other provider that is not a hospital. This Medicare Supplement benefit pays the coinsurance (generally 20% of the "Medicare approved" amount) under Medicare Part B.

There are eight additional benefits that are combined with the basic benefits in various ways to make up the eleven remaining Plans called Plan B through Plan L.

1. **The Part A Deductible:** The Medicare Part A deductible is the expense for which you are obligated to pay when you are admitted to a hospital as an inpatient. Medicare pays eligible benefits above that amount. (The Medicare Part A deductible amount may change yearly, so check the current *Medicare & You* handbook). This Medicare Supplement benefit reimburses you the deductible amount, no matter what the amount may be. This benefit is included in Plans B through L.

2. **Skilled Nursing Coinsurance:** Medicare Part A pays for the first 20 days of care in a skilled nursing facility following hospitalization, but requires you to pay a coinsurance beginning on the 21st day through the 100th day. This Medicare Supplement benefit pays the coinsurance amount beginning on the 21st day. This benefit is included in Plans C through L.

3. **Part B Deductible:** The Medicare Part B deductible is the amount you must pay each year for medical expenses (such as doctor fees) before Medicare begins paying. (The Part B deductible amount may change per year). This Medicare Supplement benefit reimburses you the deductible amount. This benefit is included in Plan C, Plan F, and Plan J.

4. **Part B Excess Charges:** Medicare Part B pays 80% of a predetermined amount (called the "Medicare approved" amount) for each procedure performed by your doctor or other medical care provider. If your doctor accepts Medicare "assignment," the provider may only bill you for the difference between the amount paid by Medicare and the amount approved by Medicare.

If your doctors do not accept Medicare assignment, they may bill you for the difference between the amount paid by Medicare and the amount they can legally charge you (called the "limiting charge"). If you have a Medicare Supplement Policy with the following:

Part B Excess Charges (100%) benefit, the policy will pay the full amount billed by your doctors or other providers who do not take Medicare assignment subject to the limiting charge. This benefit is included in Plan F, Plan I, and Plan J.

The Part B Excess Charge (80%) benefit, the policy will pay 80% of the amount you are billed by your doctors or other providers. This benefit is only in Plan G. Theoretically, you should save money on premium costs if you select the 80% benefit rather than the 100% benefit. Remember that this coinsurance amount is paid by the Medical Expenses part of the Basic Benefits that are part of every Medicare Supplement insurance policy. Policies for A through J plans must pay 50% coinsurance for outpatient mental health treatment services. This percentage is different for Plans K and L.

5. **Foreign Travel Emergency:** The original Medicare plan does not pay for medical care outside of the United States, but some Medicare managed care plans, private fee-for-service plans, and some Medicare Supplement plans do. This Medicare Supplement benefit will pay 80% of your expenses for most emergency medical care in a foreign country during the first 60 days of a trip abroad after you pay a $250 deductible. There is a lifetime maximum benefit, so check your current handbook for the dollar amount. This benefit is in Plan C through Plan J. Check your insurance coverage before you travel.

6. **At-Home Recovery:** Under the home health care benefit, Medicare pays for intermittent visits by a nurse or other skilled care provider in your home during recovery from an acute illness. Medicare does not pay for custodial care in your home such as homemaker services, (i.e. help with bathing, dressing, laundry, or shopping). This Medicare Supplement benefit pays per home visit. Check your handbook for current benefits for medically necessary custodial care while you are recovering from an illness, injury, or surgery. An insurance company may limit the number of visits to equal the number of Medicare home health care visits. This benefit is in Plan D, Plan G, Plan I, and Plan J.

7. **Basic Prescription Drug Benefit:** Until January 1, 2006 this benefit had an annual limit of $1,250. The extended prescription drug benefit has an annual limit of $3,000. Medicare does not generally pay for outpatient prescription drugs. Each of these Medicare Supplement benefits pays 50% of the cost for outpatient prescription drugs to a maximum of $1,250 or $3,000 per year depending on the plan you purchased. The basic drug benefit is in Plan H and Plan I. The extended drug benefit is in Plan J only. **Starting January 1, 2006 plans H, I, and J cannot be sold with the prescription drug benefit.**

8. **Preventive Care:** Medicare pays for some testing for diagnostic purposes. This Medicare Supplement benefit pays up to $120 per year for certain tests done for screening purposes, routine physical exams, patient education, and other medically appropriate tests or preventive measures not covered by Medicare. This benefit is included in Plan E and Plan J. Plans K and L cover 100% of the coinsurance for Part B Preventative Services.

CALIFORNIA DEPARTMENT OF INSURANCE

Medicare Supplement Coverage Comparison Chart
Plans A through L

Medicare Supplement Benefits	A	B	C	D	E	F	G	H	I	J	K	L
Basic benefits: Coinsurance for hospital days 61-150 and payment in full for 365 additional days; 20% coinsurance for physician and other Part B services after Part B deductible has been met; first three pints of blood	●	●	●	●	●	●	●	●	●	●	●	●
Hospital deductible: $952 in 2006		●	●	●	●	●	●	●	●	●	●	●
Skilled nursing facility: Coinsurance of $119 for days 21-100 in 2006			●	●	●	●	●	●	●	●	●	●
Part B deductible: $124 in 2006			●			●				●		
Part B excess charges: Part B excess charges up to 115% of Medicare's approved amount						100%	80%		100%	100%		
Emergency care outside the United States: 80% during the first two months of the trip, with $250 deductible and lifetime up to $50,000			●	●	●	●	●	●	●	●		
Annual at-home recovery benefit: Up to $40 a visit for 40 visits - $1,600 per year				●			●		●	●		
Part A hospice coinsurance: 50% of covered benefits											●	
Part A hospice coinsurance: 75% of covered benefits												●
Preventive services: Up to $120 a year if ordered by doctor					●					●		
Preventive services: 100% of Part B covered benefits											●	●
Out-of-pocket maximum: 100% of covered benefits after beneficiary pays $4,000 out of pocket											●	
Out-of-pocket maximum: 100% of covered Benefits after the beneficiary pays $2,000 out of pocket												●

* Plan F & J have high deductible options, some companies may offer these options.

Basic Benefits are included in all plans. They include: Medicare Part A coinsurance plus coverage for 365 additional days during your lifetime after Medicare benefits end; Medicare Part B coinsurance; and the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless this blood is replaced.

Note: Plan K has a $4,000 out-of-pocket annual limit. Plan L has a $2,000 out-of-pocket annual limit. Once you meet the annual limit, the plan pays 100% of the Medicare Part A and Part B co-payments and coinsurance for the rest of the calendar year. "Excess charges" from your doctor that exceed the Medicare approved amounts are not covered and do not count toward the out-of-pocket limit. You will be responsible for paying excess charges.